Tim P
BV 3/8/05

DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES

BRIAN SCHWEITZER
GOVERNOR

DR. ROBERT WYNIA
DIRECTOR

STATE OF MONTANA

Developmental Disabilities Program

RECEIVED
FEB 2 5 2005
DPHHS - DSD

TO: William Docktor, Board Chairperson MDSC
Francine Sadowski, CEO MDSC
Vasa Parsons, Director of Services MDSC

FROM: Paula Miskuly, Quality Improvement Specialist DDP

RE: MDSC's Quality Assurance Review

DATE: February 24, 2005

Attached please fine my report from this year's Quality Assurance Review. There were four Quality Assurance Observation Sheets (QAOS) generated, two require no response. The due date for response for the other two is March 15, 2005. A formal letter of completion will be sent after they are returned and approved.

It continues to be my pleasure to be affiliated with MDSC. During each review I am reminded of the quality of care your agency provides to individuals with very significant needs. Keep up the good work.

If you have any questions or comments on this report, please feel free to contact me at (406) 329 – 5418. Thank you for your cooperation with this process and for all the work you do.

Respectfully,

Paula M. Miskuly, MSEd/QMRP

Cc: Ted Spas, DDP Regional Manager (Missoula)

John Zeeck, DDP Quality Assurance Specialist (Helena)

Tim Plaska, DDP Community Services Bureau Chief (Helena)

Missoula Developmental Services Corp.
Quality Assurance Review
Period Covered: November 2003 – February 2005

Scope of Review

Missoula Developmental Services Corporation (MDSC) provides Intensive Group Home, Intensive Day/Habilitation, and transportation to sixty-two individuals. All services provided by MDSC are funded through the Montana Home and Community Based Services Waiver. They operate nine Group Homes and an Intensive Facility-Based Day Center. The agency had its last full Quality Assurance Review in November 2003.

General Areas
A. ADMINISTRATIVE

MDSC has a local Board of Directors, which meets regularly, and members remain in close contact with the CEO. Board membership includes family/guardian(s) of MDSC consumers.

The Quality Assurance Division licenses all nine MDSC Group Homes. All homes are currently licensed without exception. Group Home licensing requires strict health/safety regulations and, ultimately, a higher level of service. MDSC is in its first year of a three-year accreditation from carf. Accreditation no longer an administrative requirement, MDSC has chosen to maintain accreditation status.

MDSC maintains weekly management meetings; every six to eight weeks MDSC and DDP staff meet to address concerns, brainstorm, and create proactive strategies, giving every individual an opportunity for monthly status update and review; and Group Home and Day Services staff have monthly staff meetings. All these systems lead to excellence communication, information sharing, and follow-up.

MDSC completes staff satisfaction surveys, at least once each year. Information gathered is synthesized and analyzed to address any areas of concern. Most often, follow-up from satisfaction surveys results in provision of more training, or offering more training opportunities.

Quarterly meetings are held with the Medical Services Administrator and the Quality Improvement Specialist to review medication errors, use of prn medications and emergency restraint procedures. MDSC has continued its trend of low frequency of all of these. Specific statistics are included later in this report.

This year, there were no fiscal concerns with MDSC's contract, invoices, or client funds. MDSC serves as representative payee for the majority of its clientele. Some individuals require a monthly incurment to maintain Medicaid, there were

no problems noted in this area. MDSC continues to participate in annual A-133 Audits. From the report dated February 6, 2004 there were no findings. MDSC has a comprehensive Policy and Procedures Manual. Many of the policies are reviewed with new staff during their orientation training.

This year, the Medical department was able to secure a relationship with a new local dentist. Dental services are difficult to find for the MDSC population due to their level of care and status as Medicaid recipients. This new dentist is willing to see the consumers at the MDSC facility and will be scheduling much needed (and hard to come by) dental surgeries that require general anesthesia. See Quality Assurance Observation Sheet (QAOS # 1).

Specific Services Reviewed

A. Residential

All the Group Homes feature single bedrooms that are decorated to individual tastes. The home furnishings and decorations are tasteful. In the more behavioral homes, maintenance staff has found innovative ways to secure home furnishings so that they are not easily destroyed.

Each Program Manager works closely with his/her Assistant Manager to ensure that the home is operating smoothly, programs are run, and that all individual's needs are met. For this review, five individuals from the Group Homes were selected as a sample. During site visits, there were no significant problems noted.

i. HEALTH AND SAFETY

MDSC has a Medical Department, which is supervised by a Registered Nurse and employs LPNs to cover all shifts. Staff at non-medically Intensive Group Homes have ongoing access to nursing staff. Some individuals receiving community-based services from MDSC would not be able to be served without this level of nursing support and supervision. MDSC maintains an excellent rapport with community medical providers, and individual's medical needs are met.

There have been no concerns or issues with medication certification this year. MDSC managers and medical staff closely monitor certification status of staff. All staff complete a medication practicum with nursing staff prior to assisting with medications, and additional supervision and training is implemented if/when a staff member has been involved with medication errors. Further, nursing staff have added a self-accountability check into the review of med errors. As part of

the processing for med errors, involved staff are required to identify what part of the med process 'broke down' to have resulted in the error.

During last year's review, MDSC averaged 10 medication errors per month. Since July 2002, the monthly average has been reduced to 9.7 per month. This frequency is significant considering that MDSC is involved in assisting and supervising over 780 separate medications each day.

For individuals whose physicians have ordered prn behavioral medication, MDSC maintains a high standard of protocols and prior approvals before they can be used. At the last review, the average use pf prn medication had been stable at approximately 9 – 10 per month. This past year, the average has reduced to 4.9 prn medications for behavior per month.

All residential sites participate in monthly fire drills. The drills are conducted over a variety of shifts. MDSC has an emergency back-up system. There is always a manager on-call. Additionally, staff can access nursing staff 24 hours per day. These back-up systems are excellent and provide staff with necessary access to management/nursing to ensure safety of all individuals.

During site visits for this review, all safety checklists were completed. No problems were noted with hot water temperature. Supplies are available and chemicals are secured to protect individual's safety. Bathing procedures are posted as necessary, and included in each individual's IP.

ii. SERVICE PLANNING AND DELIVERY

Since last Quality Assurance Review, MDSC has maintained improvements seen in the Individual Planning process. All IPs are based on assessments, objectives are set and implemented on time, programs are run as specified, internal data monitoring occurs, and Quarterly Status Reports are comprehensive. A QAOS was completed as a commendation and recognition of this (See QAOS # 2).

For all individuals in the sample, complete Individual Plans are not readily accessible to direct service staff. There is no consistent way in which IP information is shared with staff. This was noted during last review. It is recommended that the Director of Services and Program Managers determine a consistent was to ensure that direct service staff review IPs and have access to IP information.

Individual Rights are reviewed on an ongoing basis through MDSC's "Me & MDSC" training. Restrictions of individual rights occur only when necessary for a health or safety concern. All proposed rights restrictions are reviewed and

approved by IP Teams at least annually. Individuals are encouraged to participate in daily routines and choices are offered throughout each day.

The Group Homes access community events, shopping, movie theatres, etc. on a routine basis. While in-home leisure supplies are available at all sites, staff seem to struggle with documentation of participation in a variety of leisure activities. It is recommended that more clear training be provided. Please see the attached Fact Sheet regarding Leisure Skills published by the American Association of Mental Retardation (AAMR).

Individual Plans are comprehensive and reflect very specific individual information. For four of five consumers in the sample, the IP objectives were the same from last to this IP period. A QAOS was completed regarding this. (See QAOS # 3). Please refer to the attached article from the AAMR.

iii. STAFFING

MDSC is lucky to have some long-term dedicated employees; the size of their workforce creates opportunities for high turnover. Five new employees were selected as a sample to review Montana Department of Justice Criminal Background Checks. All but one had the criminal background check completed. This one file appeared to be a 'fluke' as other people hired on or around the same date did have background checks completed. A QAOS was completed regarding this. (See QAOS # 4).

MDSC's Orientation training is comprehensive and well organized. All required training topics for both Group Home licensing and DDP are represented in the curriculum. Intensive service providers are required to provide DDCPT or CBT training to staff.

Staff ratios have been checked on 55 occasions since July 2004. These staff ratio checks include Day Services. The contracted staff ratio for MDSC is 1:2. Of these checks, only one resulted in a QAOS being issued due to a Group Home operating one shift with a 3:8 ratio.

Staff at each site visited were interviewed using the Staff Questionnaire. The questionnaire covers each required training topic area. All staff were able to successfully complete the questionnaire. No concerns were noted for mandatory training. During routine visits and for all visits during this review, all observed interactions between staff and consumers were exemplary.

iv. INCIDENT MANAGEMENT

MDSC is in the process of piloting the THERAP software for web-based Incident Reporting and tracking. The system will be initially piloted at two sites. This is in response to the DDP's new Incident Management Policy.

Incident Report training is conducted routinely at monthly staff meetings. All staff are aware of Mandatory Reporting for alleged or suspected Abuse/Neglect/Exploitation. There have been very few Adult Protective Services (APS) referrals this year. In each case, MDSC management conducted internal investigations with no 'founded' allegations. MDSC works closely with the local APS workers.

Incident Report and A-B-C data is analyzed during Annual and Special IPs. At this time, MDSC is able to implement proactive plans and training in order to reduce incidents.

B. Work/Day/Community Employment

For this review, six individuals receiving Intensive Day Services were included in the sample. Five of six also live in MDSC Intensive Group Homes, one accesses "day only" services.

MDSC has contracts with local Speech Therapists and an Occupational Therapist; services in these domains are available to any consumer if recommended by their IP Team. Nursing support is available during Day Service hours.
Some individuals receive home-based day support due to medical or behavioral concerns. This provides an opportunity to focus on health/behavioral needs in a safe environment.

i. HEALTH AND SAFETY

Please refer to Health and Safety information under the "residential" section of this report.

ii. SERVICE PLANNING AND DELIVERY

Please refer to Service Planning and Delivery information under the "residential" section of this report.

iii. STAFFING

Please refer to Staffing information under the "residential" section of this report.

iv. INCIDENT MANAGEMENT

Please refer to Incident Management information under the "residential" section of this report.

C. Community Supports

MDSC does not currently provide community supports services.

D. Transportation

MDSC has a vehicle fleet of approximately 21 vehicles. They own accessible vans and buses and few cars. The vehicles receive routine oil/filter and tire rotation checks every 3,000 miles and annual vehicle inspections at an automotive shop. The maintenance department completes safety checks at least twice each month. Each month direct service staff complete a vehicle checklist. This has reportedly assisted in staff developing some "ownership" of vehicle cleanliness and organization.

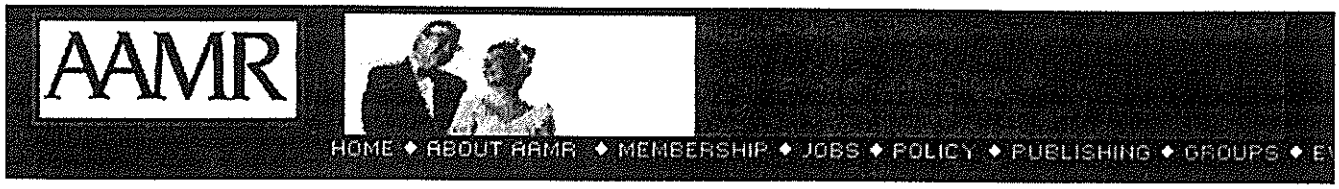
CONCLUSION

MDSC provides a wide variety of options and supports for individuals with intensive needs. The agency does a good job in maintaining health, safety, and programming for individuals across a number of sites. All Quality Assurance Observation Sheets referenced in this report have been submitted to MDSC. When all sheets are completed, a letter will be sent to formally close this year's review.

Respectfully submitted:

Paula M. Miskuly, MSEd/QMRP
Quality Improvement Specialist, DDP

Cc: Ted Spas, DDP Regional Manager
John Zeeck, DDP Quality Assurance Specialist
Tim Plaska, DDP Community Services Bureau Chief
William Docktor, MDSC Board Chairperson
Fran Sadowski, MDSC CEO
Vasa Parsons, MDSC Director of Services



▶ Policies

Legislative Goals

Policies

Position Statements

Fact Sheets

MR Definition

Professional Conduct

Fact Sheet: LEISURE

Q. What Is The Definition Of Leisure?

A. Leisure can be defined as available free choice time and those individuall characteristically are not related to work or other obligatory forms of activit expected to promote feelings of pleasure, affiliation, happiness, spontaneity, fulfillment, creativity, self-expression, and self- development. Leisure is a m activity and is essential for lifelong development and personal well-being.

Q. What Do Typical Leisure Experiences Include?

A. Typical leisure experiences include play behavior, recreation activities, di art and creative activities, adventure challenges activities, sports and game holiday celebrations, to name just a few examples.

Q. What Are Typical Leisure Skills?

A. Leisure skills include choosing and self-initiating interests, using and enjo community leisure and recreational activities alone and with others, playing taking turns, terminating or refusing leisure or recreational activities, extenc participation and expanding one's repertoire of interests, awareness, and sk

Q. How Is A Leisure Repertoire Constructed?

A. A personal leisure repertoire is constructed from the following: (a) a rang sufficient enough to develop personal preferences and interests; (b) opportu personal choice-making behavior; and (c) the depth of experience necessar feelings of pleasure, fulfillment, creativity, happiness, and other feelings con having an optimal leisure experience.

People with mental retardation will develop leisure skills and a leisure repert meaningful and structured leisure education opportunities, as well as a supp (social and physical).

AAMR Policy

People with mental retardation have the right to pursue self-determined recreation experience a leisure-oriented lifestyle. Some people with mental retardation may n services to assist in developing independence skills that support their leisure and r active consideration by local, state, national, and international organizations in rec recreation are fundamental attributes of a healthy lifestyle and are associated with people with mental retardation.

REFERENCES AND RESOURCES

AAMR Leisure and Recreation Division Newsletter. Volume V, No. 2, Leisure as an a 4. Washington, DC: American Association on Mental Retardation.

AAMR (1992). Mental retardation: Definition. classification. and systems of support American Association on Mental Retardation.

Submitted by:

Dr. Barbara A. Hawkins, Associate Professor Indiana University Department of Rec Administration, HPER Building #133, Bloomington, IN 47405-4801 Voice: (812) 85 3998. E-mail: hawkinsb@indiana.edu

---

Last Updated: February 22, 2005 2:13 PM

MENTAL RETARDATION VOLUME 40, NUMBER 5: 390–405 | OCTOBER 2002

Integrating Supports in Assessment and Planning

James R. Thompson, Carolyn Hughes, Robert L. Schalock, Wayne Silverman, Marc J. Tassé, Brian Bryant, Ellis M. Craig, and Edward M. Campbell

Abstract

A systematic approach for addressing the support needs of persons with mental retardation and related developmental disabilities is presented and a new scale to measure individual differences in support needs described. The process employed in developing the scale is explained, including the establishment of a typology of support areas that was drawn from a review of the professional literature, a validation process using *Q-sort* methodology, and a pilot field test. Critical issues and practical challenges associated with efforts to measure and address the support needs of individuals are discussed.

We are experiencing a change in the way people with mental retardation and closely related developmental disabilities are viewed and served. A "supports paradigm" has been gaining prominence in recent years, evolving from the philosophy of normalization (Nirje, 1970; Wolfensberger, 1972), the community-based movement (Bruininks, Meyers, Sigford, & Lakin, 1981), and the contemporary emphasis on quality of life (Schalock, 1996, 1997). The paradigm shift involves a movement away from a principal focus on individuals' deficits to one concerned primarily with self-determination and inclusion. The major focus is on the question, What supports are needed to help people participate in their community, assume valued social roles, and experience greater satisfaction and fulfillment? We propose that *supports* be defined as resources and strategies that promote the interests and welfare of individuals and that result in enhanced personal independence and productivity, greater participation in an interdependent society, increased community integration, and/or an improved quality of life. Although still emerging, the supports paradigm is gaining acceptance across disciplines, including education, health care, and social services/habilitation (Schalock, 2001).

Despite its conceptual appeal, the transition to a supports paradigm presents a number of clear challenges. First, people with disabilities, as consumers of supports, must be described on the basis of their personal needs and aspirations. Such a description would supplement, or perhaps supplant, an orientation that is focused on deficits; such a reconceptualization requires the development of new systems of classification. Second, the traditional focus on supports that addresses basic personal care and maintenance must be expanded to include the enhancement of personal development, empowerment, inclusion, and valued social roles. Systems of support implementation, in order to meet these challenges, need to be designed to assess a wide range of support needs, be person-centered, be sufficiently flexible to accommodate substantial variation in individual priorities, and provide a means to regularly evaluate each individual's changes in status and needs over time.

In this article we describe a four-component approach for determining support needs and developing plans that meet these needs. The four components are depicted in Figure 1 and involve (a) identifying a person's desired life experiences and goals, (b) determining an individual's intensity of support needs across a wide range of environments and activities, (c) developing an individualized support plan, and (d) monitoring outcomes and assessing the effectiveness of the plan. We also describe how a new scale was developed to measure the intensity of an individual's support needs. Each phase of the scale's development are presented, including findings from an initial field test.

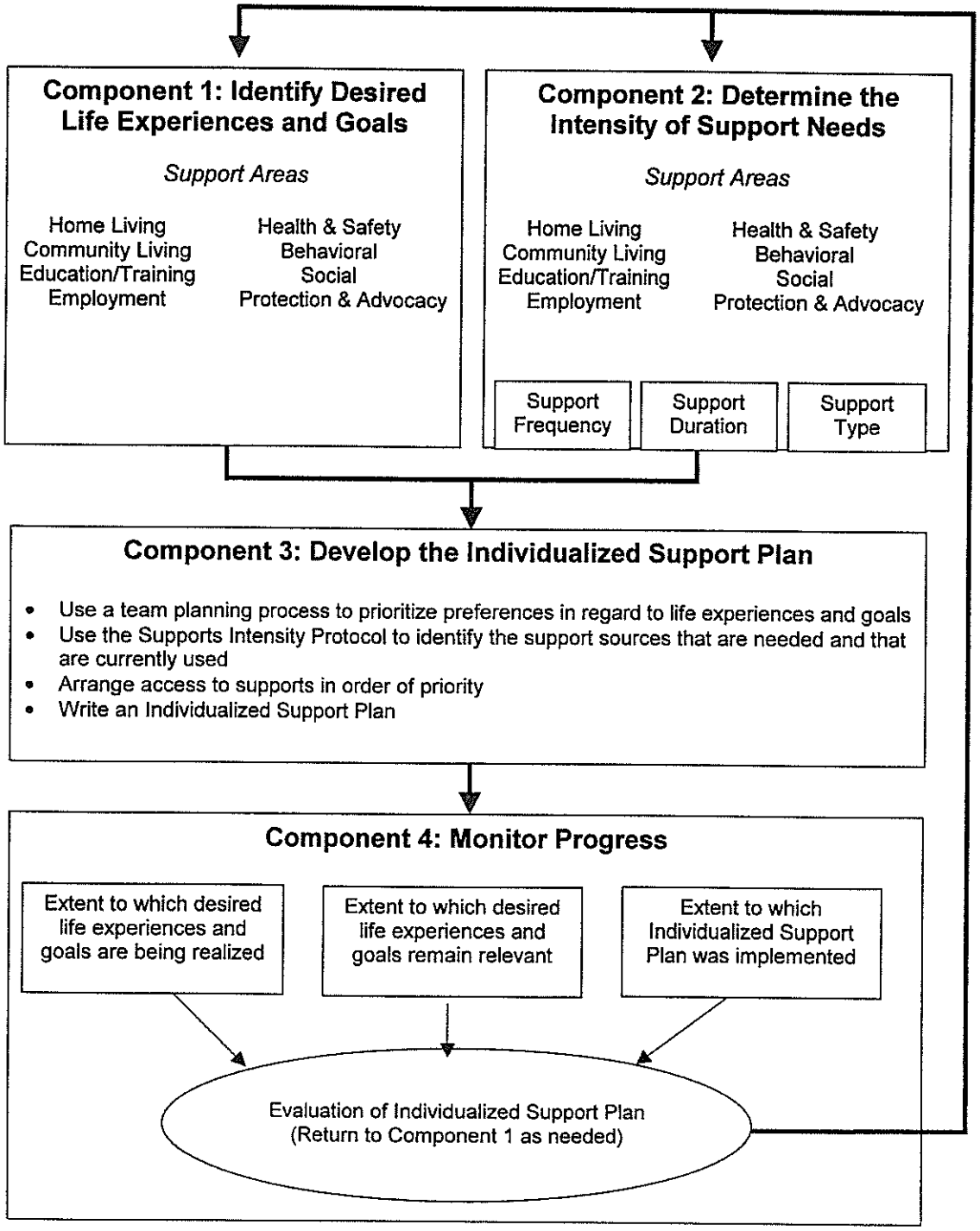


Figure 1 Four-component support needs assessment and planning process.

The four-component approach and the development of the scale were based on five assumptions about the nature of support needs of persons with mental retardation and related developmental disabilities. Each assumption is discussed below.

Five Assumptions Regarding the Nature of Support Needs

Assumption 1: Types of Support Must be Tailored to Individual Needs and Preferences

According to the American Association on Mental Retardation's (AAMR's) *Definition, Classification, and Systems of Supports* (Luckasson et al., 1992), mental retardation is a product of interactions between a person's skills and the nature and demands of the person's environment. Thus, mental retardation is typically reflected in a poor fit between what a person can do without any extraordinary assistance or support and what the environment expects. Because there is considerable variance among the demands in different environments, the levels of personal competence across individuals, and the goals and desires of different individuals, it is unlikely that any two people will have the exact same support needs or require the same support plan. Truly personalized support plans and practices will match the provision of different types of supports to individual needs and circumstances.

Assumption 2: The Provision of Support Must be Flexible

People's support needs are dynamic (i.e., they change across settings, across situations, and over time). Therefore, a support assessment, planning, and provision process should identify an array of supports that is sufficiently flexible to respond to changing circumstances. In addition, periodic reevaluations are needed to review an individual's current supports and determine whether the supports are meeting the person's needs. It is also important to identify circumstances that might call for short-term intensive supports in hopes of reducing the need for long-term supports. For example, buying an electric wheelchair and teaching someone how to operate it is an intensive support that could reduce future needs in regard to personal mobility. In much the same way, providing education to young children at risk for developmental delays is an intensive support that might lead to prevention of the need for any extraordinary support later in life.

Assumption 3: Some Supports Are More Important to Individuals Than Others

A support needs assessment and planning process must allow for the prioritization of support needs. Because many supports consume resources and because the financial resources to fund supports will always be finite, there is a great need to distinguish between supports that are priorities and those that are relatively less critical. Factors guiding the prioritization of support needs include the individual preferences of the person who is being supported and consideration of primary human needs that society is expected to provide for all citizens (e.g., safety, shelter, nourishment). The individual with the disability and his or her family should make final decisions regarding support priorities.

Assumption 4: Systematic Assessments of Support Needs Should Guide the Development and Revision of Individualized Support Plans

A support needs assessment process should produce information that maximizes awareness among planning team members as to what an individual wants in his or her life in both present and future contexts. This should promote creative problem-solving among planning team members to identify, structure, and coordinate supports. A support plan should emerge that, at a minimum, identifies (a) different *sources of support* that can either garner and/or directly provide the assistance the individual needs, (b) the *purposes* or *functions* of each type of support to be provided, and (c) the *intensity* of the support provision to most effectively meet the individual's needs.

Assumption 5: The Assessment of Support Needs Must Consider Multiple Factors

As noted by Luckasson et al. (1992), failure to consider factors related to an individual's cultural, ethnic, linguistic, and economic background or communication and behavioral characteristics might seriously compromise or invalidate the process of developing a support plan. When assessing needs, support teams must be sensitive to and respectful of differences in values, expectations, and beliefs that influence the lives of all people. Including family and friends as members of the team can

ensure that cultural and other factors are being considered in the process of support plan development. In addition, using multiple methods of obtaining information, such as informal interviews and direct observation, will increase the likelihood that the perspectives of all interested parties are included when identifying an individual's support needs.

A Four-Component Approach to Support Needs Assessment and Planning

Addressing the support needs of persons with disabilities requires a systematic analysis of what they want to do (e.g., interests, preferences) in their daily lives and the types of assistance they need to participate in the settings and activities they desire. Such assistance includes both extraordinary assistance that most other people in society do not require and typical assistance that many people in society need on a regular basis. Based on this needs analysis, a plan for providing individualized supports across a wide range of environments can be developed, implemented, and evaluated. We propose a four-component approach (Figure 1) to guide the support needs assessment and planning process. Each component is described below.

Component 1: Identify Desirable Life Experiences and Goals

A person-centered planning process is recommended for determining how a person's current life experiences conform to or differ from his or her desired life experiences and goals. A variety of different person-centered planning processes have been described (e.g., Butterworth et al., 1993; Malloy, Cheney, Hagner, Cormier, & Bernstein, 1998; Mount & Zwernik, 1988; O'Brien & Lovett, 1993; Smull & Harrison, 1992; Vandercook, York, & Forest, 1989). A common theme is focusing on the development of "a vision of the life-style the individual would like to have, and the goals needed to achieve it, that is unrestricted by current resources or services" (Butterworth, Steere, & Whitney-Thomas, 1997, p. 7). Ideally, an outcome of person-centered planning is the identification of daily experiences and daily settings/environmental conditions that provide an individual with an improved quality of life.

An interview will typically provide the best means to identify the areas of support that are most important for an individual. The principles and techniques of "person-centered planning" should guide this interview process as well as subsequent team-planning activities. Through conversations with the person, and in many cases the individual's advocates, those areas of the person's life can be identified in which change is desired. In situations where the interview reveals that an individual does not desire any changes in his or her life (i.e., "everything is fine"), it is still important to understand what supports are needed to maintain these conditions and experiences. Types of supports that the individual may want to increase or decrease include natural supports (i.e., sources of support that are naturally present in settings and activities, such as family, coworkers, neighbors, or other community members), generic supports (i.e., supports used by people without disabilities, such as public transportation), supports provided by disability services organizations (i.e., formal services that involve paid staff), and technological supports (i.e., assistive technologies).

A standardized and highly structured interview would not have sufficient flexibility to tap the key information sought at this stage. Individual differences are simply too great to permit a rigid structure to be both valid and practical, given that the emphasis is on discovering what each individual uniquely values. Nevertheless, some general uniformity needs to be maintained, and guidelines for the initial interview are as follows:

1. A conversational style should be used versus a standardized structured interview.
2. Key content areas need to be addressed during this interview (see sample questions in Table 1).
3. Although the individual's personal views are critical, it may be necessary to include caregivers or family members who are intimately familiar with the individual during this interview.
4. Avoid using questions that may be answered yes/no; open-ended questions will generally produce more detailed and useful responses.
5. Based on the person's response to your probe question, you may need to follow-up with additional inquiry in that area.
6. If major themes/goals seem to emerge from the individual's responses, confirm these issues by going over them again with him or her.
7. Confirm/validate the needed support areas with appropriate caregivers or family members.
8. Even a nonverbal individual can identify preferences when given options/choices; when a per-

Table 1 Sample Questions for Initial Interview

Domain	Sample questions
Global—Life Goals	What are your hopes and aspirations, and what can be done to help you achieve these?
Global—Relationships	Who are the key people in your life, and what types of relationships do you desire?
Home Living	Tell me about where you are living. What do you like about living there, and are there any changes you might be considering? What kind of meals are you able to prepare by yourself and with what meals do you need help? What kind of help do you need with your daily personal care (such as bathing, toileting)?
Community Living	Tell me what kinds of things you do outside the home. Where do you go shopping? How do you get around the community? Tell me about some new things that you would like to do.
Education/Training	Tell me about your reading and writing skills. Tell me what you like to read. What kind of things do you want to learn?
Employment	Are you currently employed? What do you like about your job? Tell me about the jobs you've had in the past. Tell me about what kind of job you would like to have. What kind of special assistance do you need on a job?
Health & Safety	How is your health in general? What medications do you take? What kind of exercise do you get? How safe do you feel in your neighborhood?
Behavioral	How do you get along with other people? What kind of help could you use in order to do the things you would like to do?
Social	What kind of things do you do with your family? What kind of new things would you like to do with other people? Tell me about your friends. Tell me about your boyfriend/girlfriend.
Protection & Advocacy	How do you tell people when you want to do something new? Who helps you make decisions? What do you know about self-advocacy groups?

son's preferences are not clear, consult with a family member or caregiver.

9. Have the individual, family members, and/or caregivers identify any significant health or safety issues.

The purpose of the initial interview is to identify the areas of special importance to the person with developmental disabilities. Some suggested questions for the interview are provided in Table 1. The first two questions are "big picture" questions that provide overall direction to the support planning process. The remaining questions are related to eight support areas (how these support areas were selected is discussed later in this article).

Some major themes likely will emerge from this discussion with the individual and his or her representatives. Even if there are significant limitations in verbal communication skills, an analysis of preferences and dislikes can often suggest important accommodations to make in the person's environment. It is also essential to understand the person's current level of functioning, strengths and talents, as well as any potential barriers to achieving desired changes. Health status, as well as behavioral and cognitive skills, must be taken into account.

A person's lack of experience in expressing choices or lack of opportunity to participate in a variety of community-based and other activities may limit his or her ability to state personal goals or make informed choices. Obviously, informed choices can only be made when an individual is aware of the options available. Nevertheless, the information gleaned from this initial interview should help determine priority areas that need to be addressed by the team that develops the support plan (i.e., Component 3). This planning group's primary task is to identify the necessary supports required to enable the person to achieve his or her stated goals to the maximum degree possible.

It is important that a person specifically trained to conduct person-centered planning facilitates this process. Because person-centered planning has achieved a grass-roots level of acceptance in recent years, it is likely that there is a great degree of variance in the way in which the approach is implemented. Training as a facilitator in one of the recognized approaches to person-centered planning helps ensure that the process is being used appropriately. In addition, it is critical to have the person who is actively participating in the process *not* be an employee of the organization that provides supports/services to the consumer. This addresses an inherent conflict of interest of all provider agency employees, who may be inclined to offer supports and services provided by their organization rather than utilize other appropriate supports and services to meet the individualized needs of the consumer.

Finally, although the content of the questions listed in Table 1 is important, it is most vital to discern the meaning behind the answers. For example, a consumer with a significant degree of cognitive and physical disabilities may respond that he wants to be a police officer. Although some other members participating in the planning session may view that as unrealistic, there might be some activities that the consumer associates with this goal that could be both satisfying and achievable. In this actual case, the consumer was eager to spend more time riding in a car in his neighborhood, a goal that was feasible, even though employment as a police officer was not. Although this example is a simple one, the point that it illustrates is essential. Interviewers must probe to be sure that the consumer's true intent is discovered.

Component 2: Determine the Intensity of Support Needs

The Supports Intensity Scale—SIS (Thompson et al., 2002) is a multidimensional measure designed to determine the intensity of an adult's support needs. The instrument was designed to assess support needs, determine the intensity of needed supports, monitor progress, and evaluate outcomes. Moreover, SIS results can be useful for projecting support costs and justifying access to certain types of funded services/programs (e.g., supported employment, supported living). The SIS, which is in its second stage of field development, assesses support needs according to:

- Eight support areas: home living, community living, education/training, employment, health and safety, behavioral, social, and protection and advocacy
- Four medical areas: respiratory care, feeding assistance, skin care, and "other exceptional medical needs"
- Four challenging behavior areas: externally directed destructiveness, self-directed destructiveness, sexual problem behavior, and "other challenging behaviors"

The SIS contains three separate 4-point Likert rating scales that allow users to evaluate the frequency and duration of daily support, as well as the type of support, for each specific item within the eight life areas (the selection of these areas is discussed later). It also enables the assessment of *none* to *critical* support needs in the medical and challenging behavior areas. The SIS is based on (a) a literature review of support functions to identify potential indicators of support, (b) an aggregation of potential support indicators into the support areas referenced above by a group of education and habilitation professionals, (c) an initial field test to determine the appropriateness of scale items and structure, and (d) an extensive field test on a large sample to determine reliability and validity (currently in progress). An expanded description of each of these activities is provided later in this article.

Although we are not aware of any other instruments that are comparable to the SIS in regard to scope or format, any psychometrically sound scale that includes measures of support needs could be used within the planning process that is outlined in Figure 1. It is also important to note that the SIS is appropriate to use anytime there is a need to assess an individual adult's support needs. Therefore, it can be used independently of the four-component approach for addressing the support needs that is described in this article.

Component 3: Develop the Individualized Support Plan (ISP)

The evaluation of frequency, duration, type, and sources of supports needed for each of the eight support areas included in the scale will result in a support needs profile. This profile, in conjunction with information gleaned from Component 1 (the person-centered interview), will guide planning teams in developing an ISP that specifies what, when, where, how, and by whom supports will be

provided. The purpose of an ISP is to enable an individual to have life experiences and goals that mirror his or her desired life experiences and goals as closely as possible. Moreover, an effective ISP should improve coordination and management of supports and should maximize available resources, while minimizing the chances of a person receiving supports that are ineffective, unwanted, fragmented, redundant, or otherwise unnecessary.

A planning team needs to take information from the person-centered planning and supports intensity determination components to prioritize preferences in regard to life experiences and goals. During the process of developing an ISP, the planning team may need to make compromises between what is ideal and what is realistically achievable. Although it is true that many persons with mental retardation and closely related developmental disabilities have had opportunities denied because someone in power decided a certain goal was unrealistic, it can be irresponsible to suggest that persons with disabilities should receive whatever supports they want to obtain whatever life experiences and goals they desire. None of us can do everything we want to do, and it is up to the planning team to specify priorities (perhaps even nonnegotiable priorities) and make the most out of what resources are available to support the individual. This is where a skilled facilitator can help guide the consumer and his or her team to develop a plan that addresses the consumer's true goals. When this effort is appropriately undertaken, processes will be initiated that lead to an "optimistically realistic" plan.

An ISP is ready for implementation when the planning team has specified (a) the settings where the person is most likely to be as well as the activities in which the individual will participate during a typical week and (b) the types of supports that will be provided and who (or what technology) will be providing the support. A plan should identify the type and intensity of support that will be provided throughout each day of a typical week. In addition, a good support plan will be designed to accommodate occasions when an individual has an atypical schedule, such as when he or she has an illness or is on vacation.

Component 4: Monitor Progress

Component 4 is focused on the differences between the outcomes of the support planning process that were expected and the actual outcomes, including those that were unanticipated. The process will prompt planning teams to identify obstacles and barriers to achieving desired outcomes and select strategies that can address these in the future. As is shown by the arrow in Figure 1, support assessment and planning is cyclical, in that monitoring may lead to a return to Component 1 (reexamining desired life experiences and goals) and/or Component 2 (assessing intensity of support needs).

Supports Intensity Scale

The Supports Intensity Scale—SIS (Thompson et al., 2002) was developed through a multiphase process that included a thorough review of the relevant literature, the use of *Q-sort* methodology to determine the appropriate categorization of support indicators in support areas, and a pilot test of an initial version of the scale.

Phase 1: Literature Review

Twelve initial support areas (i.e., home living, community living, schooling and education, employment, health and safety, behavioral, social, financial, personal care, self-advocacy, technological, and family) were derived from a review of the professional literature regarding support functions and quality of life. Candidate indicators of support were identified from the relevant literature by searching (a) major electronic databases (e.g., ERIC, Psychlit); (b) published assessments of adaptive behavior (e.g., Inventory for Client and Agency Planning—ICAP, Adaptive Behavior Scale—ABS), (c) relevant texts and recent review articles, and (d) unpublished government reports related to service provision. A total of 33 descriptors (e.g., supported employment, social supports, supported living) were used alone or in combination. These search efforts resulted in the identification of 130 potential indicators of support needs (e.g., shopping and purchasing goods, participating in educational decisions, socializing within and outside the family) drawn from approximately 1,500 sources.

Phase 2: Q-sort

We sought expert opinion to establish the content validity and eventual grouping of the 130 candidate support indicators using *Q-sort* methodology (McKeown & Thomas, 1988). In this second component, 74 professionals currently working in the field of developmental disabilities were asked to categorize the indicators according to the 12 support

areas that had emerged from the literature review. The following instructions were given to each respondent:

> This *Q-sort* asks you to aggregate each support indicator into one of twelve support areas where the support indicator will logically have its maximum impact. For example, "housekeeping supports" would most logically impact "home living" the most. Please complete your rating based on the following directions: 1. For each support indicator, please place a "1" in the support area column for which the respective support indicator will have its maximum and/or most logical impact. 2. If you feel that the respective support indicator would also have a *secondary* effect on a specific support area (that is, less than a maximum effect, but still an effect), place a "2" in that support area column. 3. If a support indicator has *no relation* to any of the support areas, please leave the row blank. 4. Based on your experiences, please feel free to add additional support indicators to our list and indicate (with a "1" or "2") which support area the suggested support indicator would impact.

Fifty responses were returned from individuals employed by universities, state governments, or provider agencies (68% response rate). We arbitrarily established two criteria for retention: 80% of the raters had to rate the item and the item had to have a mean rating of 1.1 or less. A sufficient number of items were retained to justify maintaining 8 of the 12 *initial* support areas (personal care, technological, family, and financial were dropped as distinct areas of support). In addition, 2 support areas were renamed (*self-advocacy* was renamed *protection and advocacy*; *schooling and education* was renamed *education and training*). The eight support areas and corresponding support indicators that were retained then were incorporated into a pilot version of a supports needs assessment scale. The resulting SIS was developed to measure support needs within each area. Further, the instrument includes sections concerning critical medical and behavioral support needs. These sections were added because certain medical conditions and challenging behaviors dictate that an individual will require maximum levels of support, regardless of his or her relative intensity of support needs in other life areas. For example, consumers who have significant support needs in terms of respiratory care can need maximum support in their daily life, regardless of their needs in the areas of home living, community living, and so forth.

Phase 3: Pilot Field Test

Participants. Forty-six raters from nine sites (New York, NY, n = 10; Morganton, NC, n = 13; Sioux Falls, SD, n = 38; Brookings, SD, n = 5; Bryan, TX, n = 5; Dallas, TX, n = 5; Temple, TX, n = 2; Casper, WY, n = 8; and Thermopolis, WY, n = 7) participated. Each rater completed the SIS on at least one individual with whom he or she worked. A total of 93 individuals with mental retardation or related developmental disabilities comprised the convenience sample for the pilot field test. The demographic characteristics of the raters and those who were rated are found in Table 2. As can be seen, the raters were predominately female European Americans with bachelor's degrees and several years of experience. Those rated were a diverse group, with good representation across such characteristics as ethnic groups, intelligence levels, and employment status.

Method. The authors sent letters to colleagues who work with adults who have mental retardation and asked them to identify professionals in their area who might be willing to help field test the instrument. Based on the referrals, 46 professionals agreed to complete the SIS on people with mental retardation with whom they worked. Each rater was sent a letter of introduction, an examiner's manual, multiple copies of the scale, and a postage-paid return envelope. Raters were asked to select adults from their caseload who represented a diverse range of skills. They were also asked to provide anecdotal comments on each item's wording, intent, and value with regards to support needs assessment.

When the completed protocols were received, data were entered and item analyses were conducted by generating internal consistency coefficients (alpha) and item-total coefficients for each of the SIS subscales. Pearson product-moment coefficients of correlation were calculated to explore the concurrent and construct validity of the scale. All data were analyzed using SPSS.

Before running the data analyses, we computed Pearson product-moment coefficients of correlation to determine whether each SIS subscale score was related to the age and gender of the people who were rated. In all instances, coefficients were less than .2, demonstrating negligible association with both variables. Therefore, neither age nor gender were included as variables in subsequent analyses.

Results. Results of the item analysis are depicted in Table 3. Internal consistency coefficients were extremely high and exceeded .90 in all instances. Several authorities have cited .90 as the acceptable level for demonstrating adequate reliability for assessment scales (e.g., Aiken, 2000; Anastasi & Urbina, 1997; Nunnally & Bernstein, 1994; Salvia & Ysseldyke, 1998), so the SIS subscales far exceed

Table 2 Demographic Characteristics of Raters and Individuals Being Rated

Variable	Percentage
Raters (n = 46)	
Gender	
Male	18
Female	82
Education	
High school diploma	2
2-year degree	10
Bachelor's degree	63
Master's degree	22
Doctorate	3
Ethnicity	
European American	97
Hispanic American	3
Years experience	
<1	7
1–2	4
3–5	14
6–10	27
>10	48
Individuals being rated (n = 93)	
Gender	
Male	62
Female	38
Age	
<21	1
21–30	38
31–40	21
41–50	21
>50	19
Intelligence levels (in quotients)	
<20	25
20–35	17
36–50	22
51–69	26
>69	10
Ethnicity	
European American	82
African American	11
American Indian/Eskimo/ Aleut	3
Hispanic American	2
Other	2
Residence	
At own home without supports	9
At own home with supports	15
At home with parents	14
Staffed apartment building	15
Foster care/live-in staff	15
Midsize group home (7–15 residents)	20
Nursing facility	1
Institution[a]	11
Presence of disabilities other than MR	
Legal blindness	14
Deafness/hearing impairment	7
Psychiatric disability	29
Developmental disability	46
Physical disability: arm/hand limitations	38
Physical disability: mobility limitations	44
Chronic health condition	25
Autism	4
Brain/neurological damage	18
Speech/language impairment	38
Learning disability	23
Other	25
Employment	
Student	12
Competitive employment	7
Supported employment	14
Sheltered employment	45
Nonpaid employment/volunteer work	1
Unemployed	11
Other	10
Primary language understood	
English	97
Spanish	1
Other	2

[a]State school/state hospital with over 15 residents.

Table 3 Item Analysis Data by Support Intensity Scale Subscale

Item	Subscale[a]							
	HL	CL	E/T	EMP	H&S	BEH	SOC	P&A
Internal consistency reliability	.97	.98	.99	.98	.98	.98	.98	.98
Median rating	2.05	1.87	1.61	1.94	1.71	1.67	1.82	1.77
Median discriminating power	.52	.54	.76	.69	.74	.74	.68	.63

Note. All coefficients significant, $p < .01$.
[a]HL = Home Living, CL = Community Living, E/T = Education/Training, EMP = Employment, H&S = Health & Safety, BEH = Behavior, SOC = Social, P&A = Protection & Advocacy.

this criterion. Also shown in Table 3 are indices of item, and therefore content, validity (Guilford & Fruchter, 1978), depicted as median discriminating powers for the items composing each subscale. Ebel (1972) and Pyrczak (1973) suggested that discrimination indexes of .35 or higher are acceptable, whereas Anastasi and Urbina (1997) and Garrett (1965) suggested that indexes as low as .20 are acceptable under some circumstances. We selected the more conservative value of .35 as our criterion for acceptability. Table 3 reveals that all median coefficients exceeded this value, demonstrating the content validity of the items that compose each SIS subscale.

The median ratings for each subscale are also shown in Table 3. Anastasi and Urbina (1997) reported that average scores should be in the midrange of possible responses, with a fairly wide dispersion, to demonstrate item variance. Given that the values range from 1 to 4 for most items, the ratings in the 2-point range that appear in Table 3 would seem to somewhat satisfy the criterion.

Criterion-related validity was explored next. This type of validity is examined by correlating results from a new scale with results measuring performance from an existing measure or individuals' estimates of abilities on the construct of interest (Hamill, Brown, & Bryant, 1992; Salvia & Ysseldyke, 1998), in this case support needs. To explore the criterion-related validity of the SIS subscales, we asked each rater to estimate on a 5-point Likert scale the overall support needs of the person being rated in each of the eight support areas defining the SIS subscales. This estimate was made prior to the scale items being completed. The estimates were correlated with the total score of each subscale (i.e., Home Living, with estimated support needs in Home Living; Social, with estimated support needs in Social, and so on); the results are reported in Table 4. As can be seen, all but one of the resulting coefficients exceeded .35, the minimum value suggested by Hamill et al. as demonstrating acceptable criterion-related and construct validity. Thus, evidence for the criterion-related validity of all SIS scores except Protection and Advocacy was secured.

Finally, construct validity of the SIS scores was examined in two ways. First, each subscale was intercorrelated with the other subscales to determine the extent to which the subscales measure the same construct, support needs. If the subscales do indeed measure the same overall construct, one would expect the coefficients to be in the moderate to very high range, or about .4 to .9 (MacEachron, 1982). Perusal of Table 5 shows the coefficients to range from .45 to .87, with a median coefficient of .715.

Reexamining Table 4 provides further exploration of the construct validity of the SIS subscales. Here, several coefficients depict the relationship between the subscales and the raters' estimates of support needs in the other areas. The results indicate that six of seven coefficients met or exceeded .35 for Home Living. The remaining subscales have the following acceptable rates: Community Living, seven of seven; Education and Training, seven of seven; Employment, four of seven; Health and Safety, six of seven; Behavioral, five of seven; Social, seven of seven; and Protection and Advocacy, six of seven. According to Hamill et al. (1992), if half of the coefficients reach .35 in magnitude, evidence of construct validity is demonstrated. This criterion was achieved for the SIS subscales.

The second examination of construct validity was conducted by comparing SIS subscale scores with scores from the ICAP (Bruininks, Hill, Weatherman, & Woodcock, 1986), a popular adaptive behavior scale. Fifty-seven people who were rated on the SIS had also been rated using the ICAP. Because the ICAP is an adaptive behavior scale and

Table 4 Intercorrelations of Supports Intensity Scale Subscales With Rater Estimates of Abilities

	Rater estimates[a]							
Subscale	HL	CL	E/T	EMP	H&S	BEH	SOC	P&A
HL	.59[b]							
CL	.53[c]	.55[b]						
E/T	.57[c]	.50[c]	.53[b]					
EMP	.38[c]	.43[c]	.46[c]	.38[b]				
H&S	.59[c]	.51[c]	.65[c]	.32[c]	.46[b]			
BEH	.32[c]	.43[c]	.37[c]	.25[c]	.35[c]	.59[b]		
SOC	.45[c]	.58[c]	.54[c]	.45[c]	.52[c]	.50[c]	.63[b]	
P&A	.60[c]	.45[c]	.49[c]	.23[c]	.41[c]	.63[c]	.47[c]	.28[b]

Note. All coefficients significant, $p < .01$.
[a]HL = Home Living, CL = Community Living, E/T = Education/Training, EMP = Employment, H&S = Health & Safety, BEH = Behavior, SOC = Social, P&A = Protection & Advocacy. [b]Coefficients evident of criterion-prediction validity. [c]Coefficients evident of construct-prediction validity.

the SIS is not, results from the latter should correlate less with the ICAP than another measure of support needs (i.e., rater estimates of support needs). Thus, in some instances, we would expect the ICAP adaptive behavior scores and the SIS scores to intercorrelate in the moderate range (about .4 to .6). In regard to the Maladaptive Indexes of the ICAP, we would expect negligible coefficients (i.e., < .2) or coefficients that are not significant at the .05 level. This is consistent with the relationship between adaptive behavior and maladaptive behavior as indicated in various test manuals (e.g., AAMR Adaptive Behavior Scales, Residential and Community Edition, 2nd edition, Nihira, Leland, & Lambert, 1993).

Table 6 summarizes the relationships among the SIS and ICAP subscales. The results are equivocal, possibly because the nature of the relationship between adaptive behavior and support needs requires further examination before concrete hypotheses can be generated. For Home Living, all six coefficients with adaptive behavior exceed .35, and all four coefficients with maladaptive behavior are not significant at the .05 level of confidence. Community Living and Health and Safety have similar findings, with five of six and four of four coefficients appearing as hypothesized for adaptive and maladaptive behaviors, respectively. However, for Education and Training, Employment, and Protection and Advocacy, the relationship to the ICAP adaptive behavior scores are either one of six or two of six meeting criterion for acceptability, indicating a

Table 5 Intercorrelations of Supports Intensity Scale Subscales With One Another

Subscale[a]	HL	CL	E/T	EMP	H&S	BEH	SOC	P&A
HL	1.00							
CL	.66	1.00						
E/T	.55	.70	1.00					
EMP	.49	.74	.84	1.00				
H&S	.75	.84	.80	.81	1.00			
BEH	.45	.73	.70	.78	.79	1.00		
SOC	.68	.82	.73	.79	.88	.85	1.00	
P&A	.47	.81	.75	.80	.85	.87	.84	1.00

Note. All coefficients significant, $p < .01$.
[a]HL = Home Living, CL = Community Living, E/T = Education/Training, EMP = Employment, H&S = Health & Safety, BEH = Behavior, SOC = Social, P&A = Protection & Advocacy.

Table 6 Intercorrelations of Supports Intensity Scale (SIS) Subscales With Inventory for Client and Agency Planning (ICAP) Subscales

ICAP subscale	SIS subscale[a]							
	HL	CL	E/T	EMP	H&S	BEH	SOC	P&A
Motor Skills	.67	.41	NS	NS	.40	NS	.11	NS[b]
Social and Community Skills	.63	.57	.31	.34	.52	NS	.49	.33
Personal Living Skills	.76	NS	NS	NS	NS	NS	.13	NS
Community Living Skills	.68	.58	.32	.38	.58	NS	.51	.32
Broad Independence Index	.51	.35	NS	NS	.36	NS	.15	NS
Internalized Maladaptive Index	NS	NS	NS	NS	NS	.32	.39	NS
Asocial Maladaptive Index	NS	NS	NS	NS	NS	NS	.24	NS
Externalized Maladaptive Index	NS	NS	NS	NS	NS	.30	.29	NS
General Maladaptive Index	NS	NS	NS	NS	NS	.37	.39	NS
ICAP Service Score	.79	.66	.39	.42	.66	.45	.61	.50

Note. Coefficients indicated as absolute values.
[a]HL = Home Living, CL = Community Living, E/T = Education/Training, EMP = Employment, H&S = Health & Safety, BEH = Behavior, SOC = Social, P&A = Protection & Advocacy. [b]Not significant at the .05 level; all other coefficients were significant at .05 or better. Because SIS and ICAP items are inversely worded, all correlations were negative.

weak relationship to adaptive behavior (although the maladaptive coefficients were as hypothesized). The Behavioral and Social SIS subscales also do not meet criterion, with one of six and two of six coefficients below .35, respectively. Also, the Behavioral and Social SIS subscales, respectively, have one and two of four coefficients depicting relationships above .35 with the maladaptive scales, which provide somewhat equivocal findings.

Discussion. When one considers all of the data exploring the construct validity of the subscales (i.e., subscale intercorrelations, correlations with rater estimates of support needs in other content areas, and the relationship with SIS scores), the results seem to provide considerable evidence of the construct validity of the SIS. Clearly, however, more research is needed.

To summarize, the item analyses support the reliability and content validity of the SIS subscales, verifying the appropriateness of the process of selecting items based on comprehensive literature review followed by a *Q-Sort* by experts in the field of mental retardation. Criterion-related validity was examined by comparing SIS scores to ratings by professionals of their clients' support needs in the eight areas assessed by the SIS subscales. The findings provide support for the criterion-related validity of seven of the eight subscales. Finally, SIS scores were examined by looking at the subscales' intercorrelations, the intercorrelation of the subscales with estimates of support needs in different content areas, and comparisons of SIS scores with the ICAP. Converging evidence for the construct validity of the SIS was evident, providing strong justification for the continued development of the instrument.

Proposed Uses of a Systematic Approach to Support Needs Assessment and Planning

Information generated from the four-component assessment and planning process can be used for a number of purposes. In this section we suggest that three primary uses will involve (a) determining ISPs, (b) identifying persons based on their intensity of needed supports, and (c) developing objective and equitable approaches to funding supports for persons with disabilities.

Individualized Support Plans

As indicated earlier, a planning team will consider an individual's personal goals and preferences as well as the nature and intensity of support needs in developing the ISP. In addition, the team must consider all of the sources of support that are available to the individual and the settings in which supports will be provided. Once an ISP is devel-

oped, the planning team must ensure that it is implemented with fidelity and as intended throughout an individual's day and throughout the year. A detailed and comprehensive ISP will specify *who* will be responsible for providing *what* type of support, and *where* and *when* the support will be provided (e.g., an ISP may identify a coworker to help an individual with limited vision choose lunch items in the cafeteria at work during lunch breaks).

Collaboration and communication among support providers and the planning team is critical to ensure that all supports are, to the greatest extent possible, provided as specified in the ISP without duplication or interruption. For example, if a family member typically drives an individual to school or work, but the family member is for any reason unavailable, the planning team must identify an effective alternative. Ongoing monitoring is critical to evaluate the extent to which the ISP is being implemented effectively as well as to determine (a) the individual's satisfaction with support received and (b) areas of support requiring modification and accommodation.

Identifying an Individual's Support Needs Level

The AAMR's 1992 definition of mental retardation and its proposed supports intensity-based classification system (Luckasson et al., 1992) highlighted the issue of measuring support needs within the field of mental retardation and closely related development disabilities. MacMillan, Gresham, and Siperstein (1993) expressed concern that the absence of instruments to measure the intensity of support needs made such a classification system "less precise and less reliable" than traditional alternatives that focused on the extent of a person's limitations/deficits. Vig and Jedrysek (1996) questioned how a support needs classification system could be relevant to young children. They pointed out that all young children "need maximum adult support in all aspects of their lives because of their young age. Attempting to specify support functions or kinds and intensities of supports for this age group is apt to be subjective or artificial" (p. 246). Luckasson, Schalock, Snell, and Spitalnik (1996) responded to Vig and Jedrysek by asserting that assessment for young children with mental retardation should center on identifying the types and intensity of supports that families of the children need. They concluded that a support need orientation was especially relevant and useful for this age group.

Although the discourse on the merits of implementing a classification system based on support needs has been enlightening, there is a danger that a false dichotomy may emerge, pitting the measurement of personal support needs against the measurement of personal competence (i.e., an individual's relative strengths and weaknesses in areas traditionally associated with intelligence and adaptive behavior). *Support needs* and *personal competence* are related but distinct constructs, and both need to be adequately assessed.

It is important to note that efforts to measure support needs are in their infancy and that there is currently no process that has gained wide acceptance. However, despite a much longer history, procedures to measure personal competence are certainly less than perfect. In terms of identifying and classifying individuals in regard to personal competence, there are considerable differences in diagnostic and classification practices across states and over time (Butterworth, Gilmore, Kiernan, & Schalock, 1999; Denning, Chamberlain, & Polloway, 2000; Frankenberger & Fronzaglio, 1991; MacMillan, Gresham, Siperstein, & Bocian, 1996). Moreover, for over 20 years, Greenspan and others have argued convincingly that components of personal competence associated with social intelligence have been overlooked during the assessment process (Greenspan, 1979; Greenspan & Driscoll, 1997; Greenspan & Granfield, 1992).

Whether people should be identified and/or classified by level of support needs or by level of personal competence should not mask the need to assess both areas, nor should it divert attention from the importance of developing reliable and valid assessment instruments to measure both areas. The SIS appears to have the potential to identify people's support needs within specific areas as well as on the basis of a summative score.

Data-Based Approach to Funding Supports

There are many factors that influence how much funding is provided to an individual for the purpose of purchasing supports (e.g., disability profile and actual needs, strength of advocacy network, service program models, geographic location, diagnostic label and classification, residential setting). One use of the four-component approach for assessing support needs that has been described in this article is to provide objective information regarding individual support needs and strengthen the weight given to this information in the process of allocat-

ing public funds. With everything else being equal, people with more significant support needs will require more resources (including funding) in order to participate in home and community life. Although decisions regarding funding formulas must always be made thoughtfully and will always be influenced by a multitude of considerations, a system for objectively identifying and measuring support needs should be among the major priorities of those who strive to achieve an equitable system for distributing public funds.

Although a support needs scale such as the SIS has the potential to provide helpful information in regard to broad decisions about the composition of funding formulas, data from an assessment scale is not going to be sufficient for resolving all budget dilemmas. As stated previously, the individual with the disability, his or her family, and other members of the support team must be prepared to make choices regarding support priorities in a world of finite resources. Information from a person-centered planning process (i.e., Component 1) should be helpful in deciding how funds are spent in individual cases.

Issues and Challenges Associated With Support Needs Assessment and Planning

Any new approach to measuring support needs and planning personalized support programs will raise significant issues and encounter challenges. These should be anticipated and addressed whenever possible to increase the likelihood of broad acceptance, adoption, and utilization. Several of these major concerns have been considered in developing the approach described in this article.

The first concern has to do with the breadth of acceptance. As of yet, no specific procedures for systematically identifying the support needs of individuals with disabilities have gained widespread acceptance. The lack of a clearly defined procedure to measure support needs may be a major reason why the AAMR's 1992 definition and classification system has not been implemented universally (Polloway, Chamberlain, Denning, Smith, & Smith, 1999). The adoption of recommendations by existing organizations and authorities is essentially discretionary. Therefore, it is important that proposals are structured to be appealing, both practically and intuitively, to as broad a community of potential users as possible. Otherwise, the proposed approach will have a narrow constituency and minimal impact on practice.

A proposed approach to assessing individual support needs must be manageable in scope if it is going to be widely adopted. Support need assessments must be concise enough to be completed in an acceptable amount of time. Moreover, they must be simple enough to permit participation by individual consumers or people with significant firsthand familiarity with the consumer's priorities. Also, assessments must entail acceptable costs.

Information collected through a support needs assessment process should capture the full range of individual needs within the population of persons with mental retardation and related developmental disabilities. Assessment scales should have adequate reliability and validity and should be sufficiently objective and representative to permit meaningful comparisons among individuals and across time within individuals.

These considerations all require that an assessment process provide sufficient structure and uniformity to permit ISPs to be developed in an objective, even-handed, dynamic, and realistic way. The situation for each consumer will be unique with respect to individual priorities and environmental settings. Further, each provider agency may have established procedures that are not readily compatible with a new approach to evaluation. Therefore, sufficient flexibility must be incorporated into the design of the assessment process to permit each support plan to be tailored to the unique needs of each individual within their particular support network.

On the other hand, a support needs assessment process should acknowledge practical constraints that are currently imposed, either by lack of support availability or the limits of consumer abilities. However, these limitations need not be permanent barriers, and a good approach to measuring needs and planning personalized support programs will encourage both the expansion of services and growth of consumer capabilities. Although a successful approach needs to address current circumstances effectively, it must also stimulate enhancements in supports availability to broaden access to best practices.

Obviously, a fine balance will need to be achieved in order to deal with these concerns successfully, and whether this has been achieved in the current case will be a matter for the future record to decide. Considering these concerns, we have

tried to maximize the chances for broad implementation of the proposed approach for determining individual needs and designing programs of supports that are most likely to be consistent with consumer priorities. Ultimately, our goal is to facilitate the provision of supports that will have the greatest positive impact on each individual's quality of life, and we believe that the approach described in this article will provide a significant step in that direction.

References

Aiken, L. R. (2000). *Psychological testing and assessment* (9th ed.). Boston: Allyn & Bacon.

Anastasi, A., & Urbina, S. (1997). *Psychological testing* (7th ed.). Upper Saddle River, NJ: Prentice-Hall.

Bruininks, R. H., Hill, B. K., Weatherman, R. F., & Woodcock, R. W. (1986). *Inventory for Client and Agency Planning*. Chicago: Riverside.

Bruininks, R. H., Meyers, C. E., Sigford, B. B., & Lakin, K. C. (1981). *Deinstitutionalization and community adjustment of mentally retarded people*. Washington, DC: American Association on Mental Deficiency.

Butterworth, J., Hagner, D., Heikkinen, B., Faris, S., DeMello, S., & McDonough, K. (1993). *Whole life planning: A guide for organizers and facilitators*. Boston: Children's Hospital, Institute for Community Inclusion.

Butterworth, J., Gilmore, D. S., Kiernan, W. E., & Schalock, R. (1999). *State trends in employment services for people with developmental disabilities: Multiyear comparisons based on state MR/DD agency and vocational rehabilitation (RSA) data*. Boston: Children's Hospital, Institute for Community Inclusion.

Butterworth, J., Steere, D. E., & Whitney-Thomas, J. (1997). Using person-centered planning to address personal quality of life. In R. L. Schalock (Ed.), *Quality of life. Volume 2: Application to persons with disabilities* (pp. 5–23). Washington, DC: American Association on Mental Retardation.

Denning, C. B., Chamberlain, J. A., & Polloway, E. A. (2000). An evaluation of state guidelines for mental retardation: Focus on definition and classification practices. *Education and Training in Mental Retardation and Developmental Disabilities, 35*, 226–232.

Ebel, R. L. (1972). *Essentials of educational measurement* (2nd ed.). Englewood Cliffs, NJ: Prentice-Hall.

Frankenberger, W., & Fronzaglio, K. (1991). States' definitions and procedures for identifying children with mental retardation: Comparisons over nine years. *Mental Retardation, 29*, 315–321.

Garrett, H. (1965). *Testing for teachers*. New York: American Book Co,

Greenspan, S. (1979). Social intelligence in the retarded. In N. R. Ellis (Ed.), *Handbook of mental deficiency: Psychological theory and research* (2nd ed., pp. 483–532). Hillsdale, NJ: Erlbaum.

Greenspan, S., & Driscoll, J. (1997). The role of intelligence in a broad model of personal competence. In D. P. Flanagan, J. L. Genshaft, & P. L. Harrison (Eds.), *Contemporary intellectual assessment: Theories, tests, and issues* (pp. 131–150). New York: Guilford.

Greenspan, S., & Granfield, J. M. (1992). Reconsidering the construct of mental retardation: Implications of a model of social competence. *American Journal on Mental Retardation, 96*, 442–453.

Guilford, J. P., & Fruchter, B. (1978). *Fundamental statistics in psychology and education*. New York: McGraw-Hill.

Hamill, D. D., Brown, L., & Bryant, B. R. (1992). *A consumer's guide to tests in print*. Austin, TX: Pro-Ed.

Luckasson, R., Coulter, D. L., Polloway, E. A., Reiss, S., Schalock, R. L., Snell, M. E., Spitalnik, D. M., & Stark, J. A. (1992). *Mental retardation: Definition, classification, and systems of supports*. Washington, DC: American Association on Mental Retardation.

Luckasson, R., Schalock, R. L., Snell, M. E., & Spitalnik, D. M. (1996). The 1992 AAMR definition and preschool children: Response from the Committee on Terminology and Classification. *Mental Retardation, 34*, 247–253.

MacEachron, A. E. (1982). *Basic statistics in the human services*. Austin, TX: Pro-Ed.

MacMillan, D. L., Gresham, F. M., & Siperstein, G. N. (1993). Conceptual and psychometric concerns about the 1992 AAMR definition of mental retardation. *American Journal on Mental Retardation, 98*, 325–335.

MacMillan, D. M., Gresham, F. M., Siperstein, G. N., & Bocian, K. M. (1996). The labyrinth of IDEA: School decisions on referred students

with subaverage general intelligence. *American Journal on Mental Retardation, 101*, 161–174.

Malloy, J., Cheney, D., Hagner, D., Cormier, G. M., & Bernstein, S. (1998). Personal futures planning for youth with EBD. *Reaching Today's Youth: The Community Circle of Caring Journal, 2*(4), 5–29.

McKeown, B., & Thomas, D. (1988). *Q methodology*. Newbury Park, CA: Sage.

Mount, B., & Zwernik, K. (1988). *It's never too early, it's never too late: A booklet about personal futures planning*. Mears Park Centre, MN: Metropolitan Council.

Nihira, K., Leland, H., & Lambert, N. (1993). *AAMR Adaptive Behavior Scales, Residential and Community Edition* (2nd ed.). Austin, TX: Pro-Ed.

Nirje, B. (1970). The normalization principle and its human management implications. *Journal of Mental Subnormality, 16*, 62–70.

Nunnally, J. S., & Bernstein, I. H. (1994). *Psychological theory* (3rd ed.). New York: McGraw-Hill.

O'Brien, J., & Lovett, H. (1993). *Finding a way toward everyday lives: The contribution of person-centered planning*. Syracuse: Syracuse University, Center on Human Policy.

Polloway, E. A., Chamberlain, J., Denning, C. B., Smith, J. D., & Smith, T. E. C. (1999). Levels of deficits or supports in the classification of mental retardation: Implementation practices. *Education and Training in Mental Retardation and Developmental Disabilities, 34*, 200–206.

Pyrczak, F. (1973). Validity of discrimination index as a measure of item validity. *Journal of Educational Measurement, 10*, 227–231.

Salvia, J., & Ysseldyke, J. E. (1998). *Assessment* (7th ed.). Boston: Houghton Mifflin.

Schalock, R. L. (Ed.). (1996). *Quality of life. Volume 1: Conceptualization and measurement*. Washington, DC: American Association on Mental Retardation.

Schalock, R. L. (1997). *Quality of life. Volume 2: Application to persons with disabilities*. Washington, DC: American Association on Mental Retardation.

Schalock, R. L. (2001). *Outcome-based evaluation* (2nd ed.). New York: Kluwer Academic/Plenum Publishers.

Smull, M., & Harrison, S. B. (1992). *Supporting people with severe reputations in the community*. Alexandria, VA: National Association of State Mental Retardation Program Directors.

Thompson, J. R., Bryant, B., Campbell, E. M., Craig, E. M., Hughes, C., Rotholz, D. A., Schalock, R. L., Silverman, W., & Tassé, M. J. (2002). *Supports Intensity Scale*. Unpublished assessment scale. Washington, DC: American Association on Mental Retardation.

Vandercook, T., York, J., & Forest, M. (1989). The McGill Action Planning System (MAPS): A strategy for building the vision. *Journal of the Association for Persons with Severe Handicaps, 14*, 205–215.

Vig, S., & Jedrysek, E. (1996). Application of the 1992 AAMR definition: Issues for preschool children. *Mental Retardation, 34*, 244–246.

Wolfensberger, W. (1972). *The principle of normalization in human services*. Toronto: National Institute on Mental Retardation.

Received 5/15/01, first decision 8/27/01, accepted 11/11/01.
Editor-in-charge: Steven J. Taylor

Authors:
James R. Thompson, PhD, Chairperson, Department of Special Education, Illinois State University, Mail Code 5910, Normal, IL 61790–5910. **Carolyn Hughes, PhD,** Professor, Department of Special Education, Vanderbilt University, Box 328, Peabody College, Nashville, TN 37203. **Robert L. Schalock, PhD,** Professor Emeritus, Hastings College, PO Box 285, Chewelah, WA 99109–0285. **Wayne Silverman, PhD,** Senior Research Scientist, New York State Institute for Basic Research in Developmental Disabilities, 1050 Forest Hill Rd., Staten Island, NY 10314. **Marc J. Tassé, PhD,** Clinical Scientist, Center for Development and Learning, University of North Carolina at Chapel Hill, CB# 7255, Chapel Hill, NC 27599. **Brian R. Bryant, PhD,** President, Psycho-Educational Services, 5114 Balcones Woods Dr., #307–163, Austin, TX 78759. **Ellis M. Craig, PhD,** Research Specialist, Texas Department of Mental Health and Mental Retardation. **Edward M. Campbell, PhD,** President, E=MC² Consulting, Inc., 502 E. Missouri, Pierre, SD 57501.

07/11/2003

STATE OF MONTANA
Department of Public Health and Human Services
Developmental Disabilities Program

QUALITY ASSURANCE OBSERVATION SHEET

No. 1

Provider: MDSC
Recipient: Susan Winn (from Sadowski)
Date: 2/23/05

DDP QIS: Paula Mashuda
Concern: Dental Services - Health + Safety

Routine Quality Assurance Review
Plan of Correction needed

DDP

OBSERVATION (What):

Susan was able to forge a relationship with a dentist who accepts Medicaid, is willing to see MDSC consumers, is able to come to MDSC for exams, AND will complete much needed dental services under general anesthesia!

Way to go!

CRITERION (Reference ARM, Contract, DD Policy, Appendix I, etc.):

ARM 37.34.702

EFFECT (What is the result):

Consumers will be receiving dental care that has been needed.

QIS Signature: Paula Mashuda Date Response Due: n/a

Provider

CAUSE (Why did it occur):

ACTION (What action will be taken to address):

Signature: _____ Response: _____

DDP

Disposition: ACCEPTED REQUESTING FURTHER REVIEW Response Date: _____

Comments: _____

Copy to (check all that apply): Regional Manager Executive Director DDP Bureau Chief
Contract File Quality Assurance Specialist President, Board of Directors Other _____

07/11/2003

STATE OF MONTANA
Department of Public Health and Human Services
Developmental Disabilities Program

QUALITY ASSURANCE OBSERVATION SHEET

No. 1

Provider: MDSC
Recipient: Lara Parsons
Date: 2/23/05

DDP QIS: Paula Moskely
Concern: IP's

Routine
☒ Quality Assurance Review
Plan of Correction needed

DDP

OBSERVATION (What):
In the last three years, MDSC has shown significant improvement in the area of IP objective implementation, data collection, data monitoring, and submission of quarterly status reports.

CRITERION (Reference ARM, Contract, DD Policy, Appendix I, etc.):
ARM 37.34.1101, et. seq.

EFFECT (What is the result):
Excellent! Individuals are receiving the services outlines in their IP's.

QIS Signature: Paula Moskely Date Response Due: n/a

Provider

CAUSE (Why did it occur):

ACTION (What action will be taken to address):

Signature: _____ Response: _____

DDP

Disposition: ACCEPTED REQUESTING FURTHER REVIEW Response Date: _____

Comments: _____

Copy to (check all that apply): Regional Manager Executive Director DDP Bureau Chief
Contract File Quality Assurance Specialist President, Board of Directors Other _____

07/11/2003

STATE OF MONTANA
Department of Public Health and Human Services
Developmental Disabilities Program

QUALITY ASSURANCE OBSERVATION SHEET

No. 3

Provider: MDSC
Recipient: [illegible]
Date: 2/23/05

DDP QIS: Paula Miskuly
Concern: IP's -

Routine
(X) Quality Assurance Review
Plan of Correction needed

DDP

OBSERVATION (What):
Four of six individuals in the sample have the same IP objectives from last IP. While continuity in care is certainly important, most of these objectives are more typical "service" objectives for services which are to be expected in an intensive service setting (ie: range of motion, hygiene, etc). It is important to note that these service objectives ARE individualized - THANKS! As Montana is moving toward a Person Centered Planning approach, MDSC should be attempting to implement more fun, functional, individual specific plans while maintaining the level of services that people should receive in an intensive setting.

CRITERION (Reference ARM, Contract, DD Policy, Appendix I, etc.):
ARM 37.34.1101, et. seq.

EFFECT (What is the result):
Folks are not receiving individualized services beyond typical intensive level care.

QIS Signature: Paula Miskuly Date Response Due: 3/15/05

Provider

CAUSE (Why did it occur):

ACTION (What action will be taken to address):

Signature: ______________________ Response: ______________

DDP

Disposition: ACCEPTED REQUESTING FURTHER REVIEW Response Date: ______

Comments: ____

Copy to (check all that apply): Regional Manager Executive Director DDP Bureau Chief Contract File Quality Assurance Specialist President, Board of Directors Other ____________

07/11/2003

STATE OF MONTANA
Department of Public Health and Human Services
Developmental Disabilities Program

QUALITY ASSURANCE OBSERVATION SHEET

No. 4

Provider: MDSC
DDP QIS: Paula Mishkuly
Routine
Recipient: Stephen Comer / Fran Sudowski
Concern: Dept. of Justice criminal background check
(X) Quality Assurance Review
Date: 2/23/05
Plan of Correction needed

DDP

OBSERVATION (What):
Of 5 new employee files checked, one did not have a State of Montana Department of Justice criminal background check. After looking through other new employee files from the same hire date, and review of MDSC hiring systems this appeared to be a fluke. In the last 2 months, HR has implemented a tracking system which will prevent a similar situation in the future.
MDSC should complete an audit of Human Resource/Personnel files to ensure other staff are not working who have not had a criminal background check.

CRITERION (Reference ARM, Contract, DD Policy, Appendix I, etc.):
ARM 37.34.2102

EFFECT (What is the result):
To ensure quality of staff and protect consumers safety the DDP requires that criminal background checks be completed for all new hires.

QIS Signature: Paula Mishkuly Date Response Due: 3/15/05

Provider

CAUSE (Why did it occur):

ACTION (What action will be taken to address):

Signature: ______________ Response: ______________

DDP

Disposition: ACCEPTED REQUESTING FURTHER REVIEW Response Date: ______

Comments: ______________

Copy to (check all that apply): Regional Manager Executive Director DDP Bureau Chief
Contract File Quality Assurance Specialist President, Board of Directors Other ______________